VINEBERG. (H.N.)

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ANTERIOR VAGINO-FIXATION OF THE UTERUS FOR BACKWARD DISPLACEMENTS; A NEW OPERATION.*

By Hiram N. Vineberg, M. D.

Mr. President and Fellows: It happens that the communication I desire to make comes at an opportune time, when the paper of the evening treats of a subject akin to the one I have under consideration. It is my wish that my remarks be received merely as a preliminary report upon an operation that has been accorded considerable interest in Germany during the present year, and which, as far as I know, has not been attempted in this city excepting by myself and a few others. I may be entirely mistaken in this, and if I am I wish some member would correct me. I have reference to anterior vagino-fixation of the uterus for backward displacements. As you all know, the modern idea of fixing the uterus to the anterior vaginal wall first originated with Sänger. In 1888 Sänger stated the theoretical possibility of incising the vaginal vault, entering the vesico-uterine space, and passing silver sutures through the vagina and body of the uterus, and thus fixing the uterus forward. But he did not put his theory into practice just then. In the same year Schücking, of Pyrmont, published an article in the *Centb. für Gyn.* (No. 12) describing his well-known method of suturing the uterus through the anterior vaginal wall. But Schücking's method has not been received with much favor, chiefly owing to the great danger of injuring the bladder,

* Read at a meeting of The New York Obstetrical Society, held Nov. 21, 1893.

and to the unsurgical procedure of thrusting a needle blindly through tissues. Furthermore, the results in the hands of other operators have not been very successful. Then in May, 1892, Mackenrodt read a paper before the Berlin Gynæcological Society describing an operation for fixing the uterus forward. The operation, as described in this paper, consisted in making a longitudinal incision through the anterior vaginal wall, separating the flaps from the underlying bladder, then making a curved incision across the lower angle of the wound, opening the vesico-uterine space, bringing the uterus forward, and passing a couple of silk sutures through the vaginal flaps and through the anterior wall of the uterus some distance above the internal os. Dührssen, who claims priority in this matter, read a paper on vagino-fixation before the Surgical Congress in June, 1892, embodying the results of one hundred and fourteen cases. It is not my purpose to-night to enter into a criticism of the difference between the two procedures, both of which have the same end in view. But I can not refrain from quoting and indorsing Fritsch's criticism on Dührssen's paper, that it would carry more weight if based on ten cases rather than one hundred and fourteen cases, and that a woman is not a "*Versuchsthier*" (an experiment animal).

The next article on the subject appeared in the *Centb. für Gyn.* for July 8, 1893, by Winter, of Berlin. This author reported fourteen cases in which he operated exactly in accordance with Mackenrodt's description, and all were failures. Believing, however, that the fault lay with the technique and not with the principle, Winter operated on eleven further cases, modifying the operation in some important details. In three cases of prolapsus with great elongation of the cervix he failed to reach the vesico-uterine space, and hence could not perform the operation. In the other eight cases the results were good excepting in one of prolapsus with marked retroflexion.

Stimulated by the claims made by Winter of his added improvements to the method, Mackenrodt described anew his technique in the *Centb. für Gyn.* for July 22, 1893. This description corresponds very closely with that given by Winter, and it is not my province to decide which is the plagiarist. I followed the description given by Winter and by Mackenrodt in his later article, selecting the details of each that seemed to me the most plausible, and making a few modifications when I thought it advisable so to do. Having said this much, I may be free to describe the operation as I have performed it, and to point out afterward in which details I have presumed to differ from either of the above-mentioned operators.

The patient is placed in the lithotomy position and the vagina and vulva are thoroughly scrubbed. I invariably precede the operation by a curettage, for even if no endometritis be present, which is unlikely, it is well to have a clean, aseptic cavity, in the event of the needle, in suturing the uterus, going through the whole thickness of the uterine wall. The value of doing a curettage before any operation during which the uterine cavity may be entered has been fully taught us by Dr. Edebohls. If there be present a pathological laceration of the cervix, this is next repaired, or an amputation done if the condition seems to demand it.

The first step of the operation consists in seizing the anterior lip of the cervix with two volsellæ and drawing the cervix downward to the vulva or outside of it, if this can be done without employing unnecessary force. The anterior vaginal wall, about three quarters or one inch from the urethral opening, is caught with another volsella and drawn upward. In this way the wall of the vagina is put on the stretch. Then a longitudinal incision is made in the median line through the anterior vaginal wall, extending from one inch below the urethral opening to the vaginal attachment of the cervix. The vaginal wall is now separated on either side from the underlying bladder, partly by sharp and partly by dull dissection. The hæmorrhage attending this part of the operation may be not inconsiderable and comes from the vaginal branches of the uterine artery.

The next step consists in holding asunder the two vaginal flaps by tenacula at the lower angle of the wound and making a slightly curved incision, with the convexity toward the cervix, down upon the cervical tissue. This incision is made in the already denuded surface and cuts through the vesico-vaginal septum. Before making it, it is well to ascertain the extent to which the bladder is adherent to the cervix so as to avoid cutting into it. The bladder is then separated from the cervix and pushed back with the finger as is done in vaginal hysterectomy, and may be carried to the upper angle of the wound, where it can be held with an ordinary vaginal depressor. A thick sound with a knob at the end is now passed into the uterus, and the uterus is anteverted so that its anterior wall presents in the vaginal wound. The next step consists in resecting a strip from each flap in cases of prolapsus of the anterior wall. The width of the resected strips is made to depend upon the degree of prolapsus and relaxation, and they together form a strip of an oval shape. Then with a stout curved needle a silk suture is passed through the right vaginal flap at the extreme upper end of the incision—that is, from three quarters

to one inch distant from the urethral opening, and about half an inch from the edge of the flap. The suture is then carried through the anterior wall of the uterus quite near to the fundus, then out through the left vaginal flap at a corresponding point to that of the opposite side. A second suture is passed in the same way about half an inch below the first. The sutures are now tied firmly and the vaginal flaps are brought together by a continuous catgut or silk suture. A couple of interrupted sutures may be passed to strengthen the line of coaptation. The lower stitches are made to catch up the cervix, to avoid any pocketing. If there be any prolapsus of the posterior wall, or a laceration of the perinæum, these are now attended to. The vagina is then packed lightly with iodoform or sublimate gauze to absorb any oozing, and the patient is placed in bed. She is kept in bed for three weeks, the uterine sutures being removed at the end of the fifth or sixth week.

The above-described technique differs from that given by Winter and Mackenrodt (1) by preceding the operation by a curettage; (2) by anteverting the uterus to such a degree that the fundus presents at the vaginal wound. I deem this quite an advantage, in that it facilitates the passing of the uterine sutures, and avoids the possibility of injuring the bladder. (3) In passing the sutures through the uterus nearer the fundus (in fact, the first is passed through the anterior surface of the fundus) than do either Winter or Mackenrodt, who state that they pass the sutures as near the fundus as possible.

This step is rendered easy by the foregoing procedure, and of its advantage there can be little doubt. It brings the uterus a little higher up in the plane of the pelvis, and consequently in a more normal position. Winter employs buried silkworm gut to fix the uterus, passing the sutures through the internal surface of the vaginal flaps. Although his results were good, the procedure did not appeal to me, for it seems rather risky to attempt to bury a non-absorbable suture in the under surface of a structure not thicker than the vaginal wall, and to pass another suture to bring its edges together. Mackenrodt and Dührssen have both tried the various materials used for sutures, and have returned to silk, which they claim has the advantage over silkworm in being more irritative, thus exciting a firmer union. I have therefore used no other suture material in my cases but silk, save in one case in which I passed an additional suture of silver wire. But this was of no avail, as will be referred to later. Dührssen makes a curved incision through the anterior vaginal wall, and fixes the uterus by three or four sutures to the upper vaginal

flaps, then brings the vaginal wound together by a continuous catgut suture. In other respects his technique differs but little from that of Winter and Mackenrodt.

I have performed the operation on four cases, and made the attempt in a fifth case in which I did not succeed, owing to my inability to reach the vesico-uterine space. This case was one of complete prolapsus of the uterus and vaginal walls, with, as is usual in this class of cases, great elongation and thinning of the cervix. I had separated the bladder from the cervix for a distance of from two and a half to three inches, and yet failed to reach the vesico-uterine space. In the other four cases I experienced but very little difficulty, save in the last one that I operated upon six days ago. The patient was a nullipara, with a very narrow vagina, a small introitus, and a very rigid perinæum. The difficulty consisted in anteverting the uterus, by the sound, within so small an arc. The rigid perinæum would not admit the lower end of the sound to pass back far enough to bring the uterus forward, and I thought I would be compelled to incise the perinæum. But I recalled a step in Dührssen's technique in which he passes two or more provisional sutures through the anterior wall of the uterus, by means of which he pulls the body downward and forward. I passed one such suture just above the internal os, and was then enabled to bring the uterus forward as in the other cases. No injury was done to the bladder in any of the cases operated upon. Four of the cases had no temperature at any time reaching above 99.5°, and for the most times being at 98.5°. In one case there was some sepsis, the patient having a chill twenty-four hours after the operation, and a temperature of 103°. This temperature continued for thirty-six hours, but has been normal since a period of thirteen days. The vaginal wound opened up and is healing by granulation, but the uterine sutures held and the uterus is in normal anteversion. Excepting the first twenty-four hours of the febrile period, the patient has been free from pain. The sepsis may have been due to one of two contingencies or to both combined: (1) a borrowed scalpel, having forgotten to bring mine; (2) the catgut, which I did not prepare myself, and for the asepticism of which, consequently, I could not vouch. No untoward symptoms were observed in any of the other cases. One patient had to be catheterized until she was allowed to get up on her knees on the twelfth day, declaring her inability at any time to void urine in the recumbent posture. The other cases voided the urine unaided from the third to the fifth day after the operation. Other than this there have been no bladder disturbances; on the contrary, there has been a

disappearance of the painful and frequent micturition that had existed in three cases prior to the operation. I will now give a brief outline of the cases.

CASE I.—Mrs. E., aged thirty; married seven years; two children and one miscarriage, last July. Symptoms: frequent micturition, the act being attended with a burning sensation; constant pain in the back, and almost constant pain across the hypogastrium. Dysmenorrhœa. Dyspareunia and leucorrhœa.

Diagnosis.—A mobile retroversion of third degree. Laceration of the perinæum; moderate prolapsus of the anterior vaginal wall.

October 4, 1893.—Curettage, vagino-fixation, anterior colporrhaphy. Tait's operation on the perinæum.

October 18*th.*—Removed perineal stitches; primary union of wound.

November 12*th.*—Removed uterine stitches; uterus in normal anteversion. All symptoms gone, excepting an occasional burning sensation in the left iliac region.

November 19*th.*—Seen patient again. Uterus in good position; patient free from symptoms.

CASE II.—Mrs. M., aged twenty-four years; married three years. Sterile; a great variety of symptoms, chief of which are backache, severe dysmenorrhœa, and bladder disturbances.

Diagnosis.—Congenital retroversion, with dense adhesions; unable to bring uterus forward except under narcosis.

October 27*th.*—Curettage, vagino-fixation, passing one silver wire and two silk sutures; resected a narrow strip from each flap to lengthen the shallow anterior vaginal wall. The uterus remained in good position for about a week, and then it gradually returned to its old faulty position.

CASE III.—Mrs. S., aged thirty years; married seven years; three children; last child three years ago; one miscarriage at two months, fifteen months ago.

Diagnosis.—Uterus retroverted to second degree; moderately adherent posteriorly. Laceration of posterior lip of cervix in median line. Left salpingo-oophoritis.

November 6*th.*—Curettage, removing from the endometrium several clear vesicles resembling those of hydatid mole. Repair of posterior lip of cervix; vagino-fixation.

November 7*th.*—Chill and temperature of 103°, the latter continuing for thirty-six hours, as already stated.

November 21*st.*—Uterus in good forward position; silk sutures

in situ ; wound in anterior wall healing by granulations ; cervix wound healed by primary union.

CASE IV.—Mrs. K., aged twenty-one years ; married three years. Sterile ; suffering for two years with constant backache and pain in the lower part of the abdomen ; has frequent and painful micturition, having to get up several times during the night.

Diagnosis.—Uterus retroverted to third degree ; readily anteverted under ether. Left tube slightly thickened. Left ovary feels larger than normal, and is far back and low down in the pelvis.

November 15th.—Vagino-fixation.

November 20th.—Uterus in good normal anteversion. Bladder and other symptoms have disappeared for the time being.

My experience with the operation is so limited and of so short a duration that I present it as stated at the outset merely as a preliminary report, and hope at some future period to communicate to this society the further results of those cases in which the operation has thus far been successful. My object in bringing the subject before the society thus early is to elicit discussion, and to ascertain if other members have had any experience with the method. In order to concentrate the discussion, I will express my present views regarding the operation, reserving the right to modify them in accordance with what a larger and more varied experience with it will teach me.

1. Vagino-fixation is a perfectly safe operation, and not difficult to perform.

2. It fixes the uterus in a more normal position than the other operations in vogue for backward displacements.

3. If unsuccessful, it is not followed by any untoward sequelæ.

4. It finds its indication (*a*) in uncomplicated mobile retroversions with symptoms when a pessary, for some reason or another, can not be worn ; (*b*) in backward displacements with moderate adhesions, which can be easily broken up under narcosis ; (*c*) in the same class of cases with more firm adhesions, but which admit of being distended by a prior course of pelvic massage ; (*d*) in prolapsus of the uterus of the first or second degree, with corresponding prolapsus of the vaginal walls ; (*e*) in retrodisplacements of the uterus, complicated with diseased annexa not calling for a radical operation —I mean salpingo-oophoritis of a moderate degree.

5. It is contraindicated (*a*) in complete prolapsus ; (*b*) in congenital retrodisplacements, with very dense adhesions ; (*c*) in those cases of retroflexion in which the fundus is very much enlarged and the isthmus atrophied to such an extent as to give the so-called

Hegar's sign in the non-gravid uterus; (*d*) in those cases of retro-displacements complicated with diseased annexa to such a degree as to call for total removal.

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Note. *December 28th.* Cases I, III, and IV have all been seen during the past week. The uterus in each instance was found to be in good anteversion, and the woman free from her former symptoms.